SPINE CENTER QUESTIONNAIRE

Primary Care Physician’s Name

Primary Care Physician’s Phone

Who referred you to the Spine Center?

Your age

Right handed

Left handed

If you are having pain, where are your symptoms located? (check all that apply)

If you are experiencing:

Are you experiencing:

Arm or leg numbness

Arm or leg weakness

Bladder problems

Pain with walking

When did your symptoms begin? ___/___/___

Can you recall a specific occurrence or activity that you believe started your symptoms? ___ No ___ Yes

If yes, describe?

Were you injured at work? ___ No ___ Yes Date

Were you injured in a motor vehicle accident? ___ No ___ Yes Date

Have you ever had pain or problems in these areas before? ___ No ___ Yes

(Doctor’s only)

MD
Have you had any prior spine surgery? ___No      ___Yes      If yes, how many operations? ______

Have you had any diagnostic test?  (Please bring all diagnostic studies and reports for your Spine Center Visit.)
__X-Rays
__MRI
__CT Scan

Are you currently taking any medications for your pain symptoms?  (List only medications used for pain.)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Does it help?</th>
<th>Side Effects?</th>
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</thead>
<tbody>
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</table>

Have you had any of the following treatments for your symptoms? (Please Check)
__Physical therapy
__Chiropractic
__Acupuncture
__Epidural Injections
__Facet Injections
__Nerve root blocks
__Other treatments

In and average week, how often do you:

<table>
<thead>
<tr>
<th>Stretch your back or neck?</th>
<th>Never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise your back or neck?</td>
<td></td>
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<tr>
<td>Lift weights for your back or neck?</td>
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<tr>
<td>Perform aerobic exercises?</td>
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</table>

What is your current work status?
__Not working because of pain
__Working but reduced hours or intensity because of pain
__Working to desired capacity despite pain
__Disabled from working because of other health problems
__Unemployed, but looking for work
__Unemployed, by choice/ Homemaker
__Retired
__Student

If you are out of work, for how long? ___What is your occupation or profession? ___________

Include elementary, high school, college, etc, how many years of school have you attended? ______

Because of your pain, are you currently receiving:

<table>
<thead>
<tr>
<th>Workers’ Compensation</th>
<th>No</th>
<th>Yes</th>
<th>Applying for workers’ compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Disability</td>
<td>No</td>
<td>Yes</td>
<td>Applying for social security disability benefits</td>
</tr>
<tr>
<td>Private Disability</td>
<td>No</td>
<td>Yes</td>
<td>Applying for private disability benefits</td>
</tr>
</tbody>
</table>

Have you hired a lawyer to help with you legal issues concerning your pain? ___No      ___Yes

Are you involved in a personal injury lawsuit because of your pain? ___No      ___Yes      ___Unsure

What is your race/ethnic background?  (Mark all that apply)
__Arabic or Middle Eastern
__Asian
__Black or African American
__Eskimo or Aleut
__Hispanic or Latino
__Indian (From India)
__Native American
__Pacific Islander
__White
__Mixed or Other ______________________________________
This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1 – Pain Intensity
☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 – Personal care (washing, dressing, etc.)
☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it is very painful.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day is most aspects of self care.
☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking
☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than 1 mile.
☐ Pain prevents me from walking more than ½ mile.
☐ Pain prevents me from walking more than 100 yards.
☐ I can only walk with a cane or crutches.
☐ I am in bed most of the time and have to crawl to the bathroom.

Section 5 – Sitting
☐ I can sit in any chair as long as I like.
☐ I can sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than 1 hour.
☐ Pain prevents me from sitting for more than ½ hour.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

Section 6 – Standing
☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives me extra pain.
☐ Pain prevents me from standing for more than 1 hour.
☐ Pain prevents me from standing for more than ½ hour.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 – Sleeping
☐ My sleep is never disturbed by pain.
☐ My sleep is occasionally disturber by pain.
☐ Because of pain I have less than 6 hours sleep.
☐ Because of pain I have less than 4 hours sleep.
☐ Because of pain I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Sex Life (if applicable)
☐ My sex life is normal and causes no extra pain.
☐ My sex life is normal and causes some extra pain.
☐ My sex life is nearly normal but is very painful.
☐ My sex life is severely restricted by pain.
☐ My sex life is nearly absent because of pain.
☐ Pain prevents any sex at all.

Section 9 – Social Life
☐ My social life is normal and causes me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g. sports, etc.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 10 – Traveling
☐ I can travel anywhere without pain.
☐ I can travel anywhere but it gives extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain restricts me to journeys of less than one hour.
☐ Pain restricts me to short necessary journeys less than 30 minutes.
☐ Pain prevents me from travelling except to receive medical treatment.

Score ________/_________ = ________%
Please circle “Y” of “N” if you currently have the problem in the first column. *If you do not have the problem, skip to the next problem.* If you do have the problem, please indicate in the second column if you receive medications or some other type of treatments for the problem, and list them in the third column. Then in the fourth column, indicate if the problem limits any of your daily activities. Finally, at the end please list all additional medical conditions and daily medication.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>Do you have the problem?</th>
<th>Do you receive treatment for it</th>
<th>List medications or treatment</th>
<th>Does it limit your activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Lung disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Ulcer or stomach disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Liver disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Anemia or other blood disease</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Cancer, Type_________</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Date of Diagnosis _____</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression / Anxiety</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Osteoarthritis _______</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>(degenerative arthritis other than spine)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic pain in other areas</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Where________________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Y</td>
<td>N</td>
<td></td>
<td>Y</td>
</tr>
</tbody>
</table>

**List other medical problems and daily medications**

| __________________    | Y                         | N                               |                               | Y                            |
| __________________    | Y                         | N                               |                               | Y                            |
| __________________    | Y                         | N                               |                               | Y                            |

Do you regularly take

- Aspirin? _____
- Blood thinners? _____
- Anticoagulants? _____
Have you ever been hospitalized for a medical or psychiatric illness?

Please list any surgeries

Please list all allergies to medications

Do you use tobacco? No   Yes  Packs per day  Total Years

Do you drink alcohol? No   Yes  How many drinks per week?

Social History: Marital status Children

Have you ever felt unsafe at home? No   Yes

Have you ever been harmed (hit) or threatened by someone close to you? No   Yes

Is there anything occurring in your family or home life which is upsetting you? No   Yes

Approximate weight  Ideal weight  Approximate Height

Do you have any of the following problems? (Please check)

- Headaches
- Seizures, Head injuries
- Loss of concentration, memory problems
- Visual or hearing impairments, glaucoma
- Loss of coordination, tremor, balance problems
- Asthma or respiratory problems
- Chest pain, heart diseases, hypertension, murmurs, arrhythmias
- Elevated cholesterol
- Abdominal pain
- Stomach problems, ulcers, hiatal hernias
- Colitis, irritable bowel, digestive problems
- Hepatitis or liver disease
- Diabetes
- Rheumatoid Arthritis
- Osteoarthritis
- Osteoporosis
  - Date of last bone density
- Kidney, urine or bladder problems
- Pelvic pain

Does anyone in your family have a history of:

- Heart disease
- Cancer
- Neuropathy of Neurological problems
- Arthritis
- Disc herniation
- Spinal Stenosis
- Spine surgery
- Chronic pain
- Scoliosis

Date of last bone density

For Women

- Menstrual difficulty or possibility of pregnancy
- Abnormal Pap smear
- Abnormal mammography

For Men

- Prostate problem
- Abnormal PSA
**SPINE CENTER QUESTIONNAIRE**

Date: _______________  Patient Name _____________________________

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<table>
<thead>
<tr>
<th>CERVICAL</th>
<th>MAXIMUM (°)</th>
<th>PAINFUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLEXION</td>
<td>___________</td>
<td>_______</td>
</tr>
<tr>
<td>EXTENSION</td>
<td>___________</td>
<td>_______</td>
</tr>
<tr>
<td>SIDE FLEXION</td>
<td>R L R L</td>
<td></td>
</tr>
<tr>
<td>ROTATION</td>
<td>R L R L</td>
<td></td>
</tr>
</tbody>
</table>

**PALPATION**

<table>
<thead>
<tr>
<th>SHOULDER</th>
<th>ELBOW</th>
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<tr>
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</table>

**NEUROLOGICAL**

<table>
<thead>
<tr>
<th>NEURONAL</th>
<th>MOTOR (GRADE 1-5)</th>
<th>SENSORY (PIN PRICK)</th>
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</thead>
<tbody>
<tr>
<td>C-5</td>
<td>BICEPS</td>
<td></td>
</tr>
<tr>
<td>C-6</td>
<td>PRONATOR</td>
<td></td>
</tr>
<tr>
<td>C-7</td>
<td>TRICEPS</td>
<td></td>
</tr>
<tr>
<td>C-8</td>
<td>INTRINSIC</td>
<td></td>
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<tr>
<td>T-1</td>
<td>ADM</td>
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<tr>
<td>REFLEXES</td>
<td>RIGHT</td>
<td>LEFT</td>
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<td></td>
<td>___________</td>
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</table>

**THORACIC SPINE**

<table>
<thead>
<tr>
<th>MAXIMUM (°)</th>
<th>PAINFUL</th>
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<tbody>
<tr>
<td>ROTATION</td>
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</table>

**DEFORMITY**

<table>
<thead>
<tr>
<th>LUMBAR (STANDING)</th>
<th>MAXIMUM (°)</th>
<th>PAINFUL</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLEXION</td>
<td>___________</td>
<td>_______</td>
</tr>
<tr>
<td>EXTENSION</td>
<td>___________</td>
<td>_______</td>
</tr>
<tr>
<td>SIDE FLEXION</td>
<td>R L R L</td>
<td></td>
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</table>

**HIP**

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<tr>
<th>KNEE</th>
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**ROOT TENSION SIGNS**

<table>
<thead>
<tr>
<th>STRAIGHT LEG RAISING (°)</th>
<th>PAIN</th>
</tr>
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<tbody>
<tr>
<td>FEMORAL STRETCH</td>
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**NEUROLOGICAL**

<table>
<thead>
<tr>
<th>QUAD</th>
<th>DORSI</th>
<th>E H L</th>
<th>HIP ABD</th>
<th>CALF</th>
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<td>L2</td>
<td>L2</td>
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<td>L3</td>
<td>L4</td>
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<td>L4</td>
<td>L5</td>
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<td></td>
<td>L5</td>
<td>S1</td>
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**REFLEXES**

<table>
<thead>
<tr>
<th>PATELLA</th>
<th>ACHILLES</th>
<th>BABINSKI</th>
<th>CLONUS</th>
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<tbody>
<tr>
<td>___________</td>
<td>_______</td>
<td>_______</td>
<td>_______</td>
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**WADDELL**

<table>
<thead>
<tr>
<th>OVER REACT</th>
<th>SUP TEND</th>
<th>DIS SLR</th>
<th>SIMUL ROT</th>
<th>GLOBAL</th>
</tr>
</thead>
</table>

**SCAR:** ____________________  **POSTURE:** ____________________  **GAIT:** ____________________

**VASCULAR**

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<tr>
<th>RIGHT</th>
<th>LEFT</th>
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**ATROPHY**

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<th>LEFT</th>
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**PALPATION**

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